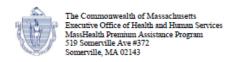




FORM #1: Please fill out the information on this page and give your EMPLOYER FORM #2

Are you and/or your family covered by health insurance other than MassHealth?							
If YES, which type: Employer COBRA							
Have you and/or your family withdrawn from health insurance within the last six months? ☐ YES ☐ NO							
If YES, Please name the plan?							
End date & reason for withdrawal?							
If you have health insurance please complete this section.							
Policy Holder:							
Address:							
City:	State:	Zip:					
Home Telephone: Work Telephone:							
SSN:	DOB:						
Medical Insurance Company:							
Policy Number (Mandatory):							
Type of Coverage: □ Individual □ Dual □ Couple □ Family							
Effective Date of Policy:	End Date:	Other:					
List all members covered under the policy							
Name	SSN	Date of Birth	Effective date				





FORM #2 : Employee Name: !	SSN: XXX-XX	C- (
Has employment terminated for the empl (If YES, Please sign this form and return to th			□NO			
Employer Name:						
Address:	Name of Co	ntact:	Ext:			
City: St	ate:Zip:	Phone	Number:			
Federal Tax ID (Mandatory):		Fax Number:_				
How many full time employees do you have?						
	Health Plan#1	Health Plan #2	Health Plan #3	Health Plan #4		
NAME AND TYPE OF PLAN:						
LEVEL OF COVERAGE OFFERED						
	☐ Individual ☐ Dual	□ Individual □ Dual	☐ Individual ☐ Dual	□ Individual □ Dual		
	☐ Couple ☐ Family					
Family Coverage						
Total Monthly Premium						
Employer Contribution						
Employee Pays Monthly						
Group #						
Open Enrollment Dates						
Signature Of Person Completing Form _	-	-	Date :			



The Commonwealth of Massachusetts Executive Office of Health and Human Services MassHealth Premium Assistance Program 519 Somerville Ave #372 Somerville, MA 02143



Premium Assistance Review Form

Please review the information below to ensure it is accurate. If the information is not correct, please write in the correct information so we may update our files. If any of the health insurance information for this individual is not already filled in, please report the correct information

	INFORMATION ON FILE	CURRENT INFORMATION - (IF
		DIFFERENT)
Policy Holder/Member		
Employer Name		
Employer's Human		
Resource Address		
Insurance Company		
Plan Name	-	
Type of Plan		□ HMO □ PPO □ POS □ EPO
		☐ Major Medical ☐ Indemnity
Plan Tier		□ Individual □ Dual □ Couple □
		Family
Policy Number		
Group Number		
Policy Start Date:		
(MM/DD/YYYY)		
Total Monthly Plan		
Amount		
Monthly Employer		
Contribution		
Monthly Employee		
Contribution		
Rate Year (dates premium		
rates are effective): Individuals covered by		
-		
Policy (MassHealth ID)		